4-4-12

RE: Metro Treatment Center
1823 Business Park Blvd.
Daytona Beach, FL 32114

Dear Property/Business Representative,

All new construction Fire Inspection finals at the above property have been completed. (Reference Permit # C111-053).

It is the building tenants' responsibility to schedule a Business Tax Receipt (formerly Occupational License) inspection in order to open up the business.
This is a formality and, although subject to re-inspection once the tenant moves in, all Fire Code requirements have currently been met at this facility for the above listed tenant.
The Business Tax Receipt Inspection can be scheduled by calling (386) 671-8178.

Please feel free to contact me regarding any questions pertaining to this matter.

Sincerely,

Inspector Brian Sievertson
City of Daytona Beach Fire Department
386-671-8164
SievertsonB@codb.us

# STATE OF FLORIDA
# DEPARTMENT OF HEALTH
# INVESTIGATIVE SERVICES

FLORIDA DEPARTMENT OF HEALTH

WWW.DOH.STATE.FL.US

## CLASS II INSTITUTIONAL PHARMACY -TYPE "A" "B" OR "C"

File # 6141
Insp # _____

ROUTINE ☐ CHANGE LOC ☒ NEW ☐ CURRENTLY NOT OPERATING ☐ CHANGE OWNER ☐

INSPECTION AUTHORITY - CHAPTER 465.017, CHAPTER 893.09 AND CHAPTER 456, FLORIDA STATUTES

PERMIT TYPE: TYPE A ☐ TYPE B ☒ TYPE C ☐

| | | | |
|---|---|---|---|
| NAME OF ESTABLISHMENT<br>Metro Treatment Center | | PERMIT NUMBER<br>15620 | DATE OF INSPECTION<br>4/11/2012 |
| DOING BUSINESS AS<br>Daytona Methadone Treatement Center | | DEA NUMBER<br>RS0182763 | CONSULTANT PHARMICIST |
| STREET ADDRESS<br>1823 Business Park Blvd | | TELEPHONE #<br>386-254-1931 Ext # | Wayman Ethridge |
| CITY<br>Daaaytona Beach | COUNTY<br>VOLUSIA | STATE/ZIP<br>32114 | CONSULTANT PHARMICIST LICENSE #<br>PU 4157 |

| PRESCRIPTION DEPARTMENT HOURS | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Open | 5-11 | 5-11 | 5-11 | 5-11 | 5-11 | 5:30-9 | 5:30-9 |
| Close | | | | | | | |

REGISTERED PHARMACIST/INTERN/TECHNICIAN LICENSE #
1.
2.
3.

| | | SATISFACTORY | N/A | YES | NO |
|---|---|---|---|---|---|
| 1 | Current modified Class II Institutional Pharmacy permit. [465.019(2)(c), F.S.] | | | ☒ | ☐ |
| 2 | Current professional supervision of a consultant pharmacist. [465.019(5), F.S.] | | | ☒ | ☐ |
| 3 | Current modified Class II Institutional Pharmacy permit. displayed. [64B16-27.100(1), F.A.C.] | | | ☒ | ☐ |
| 4 | Current DEA registration.[21CFR 1301.11] [465.023(1)(c), F.S.]* | | ☐ | ☒ | ☐ |
| 5 | Pharmacy has policy and procedures manual available for inspection. [64B16-28.702(5), F.A.C.] | | | ☒ | ☐ |
| 6 | Records reflect on-site consultations by consultant pharmacist at least monthly unless otherwise directed by Board. [64B16-28.702(2) (b) to (d), F.A.C.] | | | ☒ | ☐ |
| 7 | All medication properly labeled. [64B16-27.101), F.A.C.] | | | ☒ | ☐ |
| 8 | Pharmacy Services Committee meets at least annually. [64B16-28.702(6)(c)1, F.A.C.] | | | ☒ | ☐ |
| 9 | Provisions for handling of emergency box including the utilization of separate logs for record keeping. [64B16-28.702(6)(c)2, F.A.C.] | | | ☒ | ☐ |
| 10 | Provision for secure ordering, storage and record keeping of all medicinal drugs at facility. [64B16-28.702(6)(c)3, F.A.C.] | | | ☒ | ☐ |
| 11 | Secure storage of the medicinal drugs. [64B16-28.702(6)(c)5, F.A.C.] | | | ☒ | ☐ |
| 12 | Records of consultations for the facility for not less than two years available for inspection. [64B16-28.702(b)(6), F.A.C.] | | | ☒ | ☐ |
| 13 | Records within the pharmacy of drugs administered to patients of institutional program. [64B16-28.702(1), F.A.C.] | | | ☒ | ☐ |
| 14 | CQI Policy and Procedures and proof of quarterly meetings protected under [ 766.101, F.S.] [64B16 -27.300, F.A.C] | | | ☒ | ☐ |

* ***Questions with (*) may be answered n/a (not applicable).***

| | | SATISFACTORY | N/A | YES | NO |
|---|---|---|---|---|---|
| | **TYPE "A" MODIFIED CLASS II INSTITUTIONAL PHARMACY** | | | | |
| 15 | Quantity of controlled substances stocked does not exceed 100 dosage units PER CONTAINER unless approved by Board. [64B16-28.702(7), F.A.C.] | | | | |
| 16 | Proof of use forms used for all medicinal drugs within the facility. [64B16-28.702(7), F.A.C.] | | | | |
| 17 | Drugs stocked in establishment are those employed for treatment of primary condition or medical objective set forth in policy and procedures manual. [64B16-29.702(6), F.A.C.] | | | | |
| 18 | Pharmacy stocks no more than 15 medicinal drugs. [64B16-28.702(2)(b), F.A.C.] | | | | |
| 19 | The policy and procedures contain the drugs and strengths stocked. [64B16-28.702(6)(a)1, F.A.C.] | | | | |
| 20 | Controlled substances inventory taken on biennial basis and available for inspection. [893.07(1) (a), F.S.]* | | | | |
| | **TYPE "B" MODIFIED CLASS II INSTITUTIONAL PHARMACY** | | | | |
| 21 | Utilization of perpetual inventory system for all controlled substances; for injectables and other medicinal drugs as required by the pharmacy committee. [64B16-28.702(6)(b)(4), F.A.C.]* | | ☐ | ☒ | ☐ |
| 22 | Drugs stocked in establishment are those employed for treatment of primary condition or medical objective set forth in policy and procedures manual. [64B16-28.702(6), F.A.C.] | | | ☒ | ☐ |
| 23 | Controlled substances inventory taken on biennial basis and available for inspection. [893.07(1)(a), F.S.]* | | ☐ | ☒ | ☐ |
| | **TYPE "C" MODIFIED CLASS II INSTITUTIONAL PHARMACY** | | | | |
| 24 | Utilization of a medication administration record (MAR) for all medicinal drugs administered to patients of the facility. [64B16-28.702(6)(c)4, F.A.C.] | | | | |

Remarks: Daytonametro@cmglp.com

I have read and have had this inspection report and the laws and regulations concerned herein explained, and do affirm that the information given herein is true and correct to the best of my knowledge. I have received a copy of the Licensee Bill of Rights.

PRINT NAME Bettye Ivey

ID ji70

Institutional Representative

04-11-2012
Date

Investigator/Sr. Pharmacist Signature

INV 362 Revised 12/11, 01/07 Replaces 06/02

6. Proof of Insurance

☑ Property

☑ Professional Liability

# ACORD EVIDENCE OF C MMERCIAL PROPERTY INSL ANCE

DATE (MM/DD/YYYY): 7/10/2012

**THIS EVIDENCE OF COMMERCIAL PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.**

| | |
|---|---|
| **PRODUCER NAME CONTACT PERSON AND ADDRESS** / **PHONE (A/C. No. Ext):** (816) 960-9000<br>Lockton Companies, LLC-1 Kansas City<br>444 W. 47th Street, Suite 900<br>Kansas City MO 64112-1906 | **COMPANY NAME AND ADDRESS** / **NAIC NO:** 26620<br>AXIS Surplus Insurance Company |
| **FAX (A/C. No):** / **E-MAIL ADDRESS:** | IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH |
| **CODE:** COLMA02 / **SUB CODE:** / **AGENCY CUSTOMER ID #:** | **POLICY TYPE** Property |
| **NAMED INSURED AND ADDRESS** 1107280<br>COLONIAL MANAGEMENT GROUP, L.P.<br>8529 SOUTH PARK CIRCLE<br>SUITE 270<br>ORLANDO FL 32819 | **LOAN NUMBER** / **POLICY NUMBER** ECF747026-12<br>**EFFECTIVE DATE** 3/23/2012 / **EXPIRATION DATE** 3/23/2013 / ☐ CONTINUED UNTIL TERMINATED IF CHECKED |
| **ADDITIONAL NAMED INSURED(S)**<br>METRO TREATMENT OF FLORIDA, L.P. | **THIS REPLACES PRIOR EVIDENCE DATED:** |

**PROPERTY INFORMATION (Use REMARKS on page 2, if more space is requred)** ☒ **BUILDING OR** ☐ **BUSINESS PERSONAL PROPERTY**

**LOCATION/DESCRIPTION** DMTC
DAYTONA METHADONE TREATMENT CENTER
1823 BUSINESS PARK BLVD.
DAYTONA FL

BUILDING: $971,000; CONTENTS: $193,819; BUSINESS INCOME: $387,194

**THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.**

**COVERAGE INFORMATION** PERILS INSURED ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

| | YES | NO | N/A | | |
|---|---|---|---|---|---|
| COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $ | | | | 19,413,572 | DED: 5,000 |
| ☒ BUSINESS INCOME ☐ RENTAL VALUE | X | | | If YES, LIMIT: INCLUDED | Actual Loss Sustained; # of months: |
| BLANKET COVERAGE | X | | | If YES, indicate value(s) reported on property identified above: $ | |
| TERRORISM COVERAGE | | X | | Attach Disclosure Notice / DEC | |
| IS THERE A TERRORISM-SPECIFIC EXCLUSION? | | X | | | |
| IS DOMESTIC TERRORISM EXCLUDED? | X | | | | |
| LIMITED FUNGUS COVERAGE | | X | | If YES, LIMIT: | DED: |
| FUNGUS EXCLUSION (If "YES", specify organization's form used) | | X | | | |
| REPLACEMENT COST | X | | | | |
| AGREED VALUE | | X | | | |
| COINSURANCE | | X | | If YES, % | |
| EQUIPMENT BREAKDOWN (If Applicable) | X | | | If YES, LIMIT: 20,048,224 | DED: |
| ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg | X | | | | |
| - Demolition Costs | X | | | If YES, LIMIT: INCLUDED | DED: |
| - Incr. Cost of Construction | X | | | If YES, LIMIT: 1,000,000 | DED: |
| EARTH MOVEMENT (If Applicable) | | X | | If YES, LIMIT: | DED: |
| FLOOD (If Applicable) | X | | | If YES, LIMIT: 2,500,000 | DED: 100,000 |
| WIND / HAIL (If Subject to Different Provisions) | X | | | If YES, LIMIT: 5% OF VALUE | DED: *SEE BELOW* |
| PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS | | X | | | |
| | | | X | | |

**CANCELLATION**

**SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.**

**ADDITIONAL INTEREST** TC

| | |
|---|---|
| ☐ MORTGAGEE ☐ LENDERS LOSS PAYABLE ☐ CONTRACT OF SALE | **LENDER SERVICING AGENT NAME AND ADDRESS** |
| **NAME AND ADDRESS**<br>400206 FOR INFORMATION PURPOSES | **AUTHORIZED REPRESENTATIVE** Ronald J Foster |

# CERTIFICATE OF LIABILITY INSURANCE 3/23/2013

DATE (MM/DD/YYYY) 7/10/2012

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

| | |
|---|---|
| PRODUCER Lockton Companies, LLC-1 Kansas City<br>444 W. 47th Street, Suite 900<br>Kansas City MO 64112-1906<br>(816) 960-9000 | CONTACT NAME:<br>PHONE (A/C, No, Ext):<br>FAX (A/C, No):<br>E-MAIL ADDRESS: |
| INSURED 1349225 COLONIAL MANAGEMENT GROUP, L.P.<br>8529 SOUTH PARK CIRCLE<br>SUITE 270<br>ORLANDO FL 32819 | INSURER(S) AFFORDING COVERAGE — NAIC #<br>INSURER A : Darwin Select Insurance Company — 24319<br>INSURER B :<br>INSURER C :<br>INSURER D :<br>INSURER E :<br>INSURER F : |

COVERAGES COLMA02 TC CERTIFICATE NUMBER: 11910237 REVISION NUMBER: XXXXXXX

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | TYPE OF INSURANCE | ADDL INSR | SUBR WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS | |
|---|---|---|---|---|---|---|---|---|
| A | GENERAL LIABILITY | N | N | 03074106 | 3/23/2012 | 3/23/2013 | EACH OCCURRENCE | $ 1,000,000 |
| | X COMMERCIAL GENERAL LIABILITY | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $ 50,000 |
| | CLAIMS-MADE X OCCUR | | | | | | MED EXP (Any one person) | $ 5,000 |
| | | | | | | | PERSONAL & ADV INJURY | $ 1,000,000 |
| | | | | | | | GENERAL AGGREGATE | $ 3,000,000 |
| | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | | | PRODUCTS - COMP/OP AGG | $ 1,000,000 |
| | POLICY PRO-JECT LOC | | | | | | | $ |
| A | AUTOMOBILE LIABILITY | N | N | 03074106 | 3/23/2012 | 3/23/2013 | COMBINED SINGLE LIMIT (Ea accident) | $ 1,000,000 |
| | ANY AUTO | | | | | | BODILY INJURY (Per person) | $ XXXXXXX |
| | ALL OWNED AUTOS / SCHEDULED AUTOS | | | | | | BODILY INJURY (Per accident) | $ XXXXXXX |
| | X HIRED AUTOS / X NON-OWNED AUTOS | | | | | | PROPERTY DAMAGE (Per accident) | $ XXXXXXX |
| | | | | | | | | $ XXXXXXX |
| A | UMBRELLA LIAB OCCUR | N | N | 03074105 | 3/23/2012 | 3/23/2013 | EACH OCCURRENCE | $ 10,000,000 |
| | X EXCESS LIAB X CLAIMS-MADE | | | | | | AGGREGATE | $ 10,000,000 |
| | DED RETENTION $ | | | | | | | $ XXXXXXX |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N | N/A | | NOT APPLICABLE | | | WC STATU-TORY LIMITS / OTH-ER | |
| | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) | | | | | | E.L. EACH ACCIDENT | $ XXXXXXX |
| | If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | E.L. DISEASE - EA EMPLOYEE | $ XXXXXXX |
| | | | | | | | E.L. DISEASE - POLICY LIMIT | $ XXXXXXX |
| A | PROFESSIONAL LIAB-<br>PER CLAIM<br>RETRO DATE= 12/15/04 | N | N | PFP1000067P3 | 3/23/2012 | 3/23/2013 | $1,000,000 EACH MEDICAL INCIDENT<br>$3,000,000 AGGREGATE | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES /(Attach ACORD 101, Additional Remarks Schedule, if more space is required)

RE: METRO TREATMENT OF FLORIDA, L.P. DBA DAYTONA METHADONE TREATMENT CENTER, 1823 BUSINESS PARK BLVD., DAYTONA, FL

CERTIFICATE HOLDER

11910237

FOR INFORMATION PURPOSES ONLY

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

7. Local Zoning Compliance

# The CITY OF DAYTONA BEACH

DEVELOPMENT & ADMINISTRATRIVE SERVICES/PERMIT & LICENSING DIVISION
301 S. RIDGEWOOD AVENUE
DAYTONA BEACH, FLORIDA 32114
PHONE (386) 671-8140
FAX (386) 671-8149


*VIA EMAIL*
*jlovern@cmglp.com*

March 16, 2011

Mr. Jamie Lovern
Director of Facilities Management
Colonial Management Group, LP
8529 Southpark Circle, Suite 270
Orlando, FL 32819

RE: 1821 Business Park Boulevard, Daytona Beach, Florida

Dear Mr. Lovern:

This is to advise you that the laws and regulations of the City of Daytona Beach Land Development Code govern the zoning and use of the above-captioned property. The zoning of the property is M-4 (Industrial Park).

The proposed use of the site, a professional service, Metro Treatment of Florida, dba Daytona Methadone Treatment Center, is a permitted use in the district.

Should you require anything further, please feel free to contact me either via email at milesc@codb.us or phone at 386-671-8151.

Sincerely,

Colleen Miles
Zoning Officer

/cm

8. Local Business Tax

# THE CITY OF DAYTONA BEACH

## BUSINESS TAX # BT-34096

THE CITY OF DAYTONA BEACH
301 S. RIDGEWOOD
DAYTONA BEACH, FL 32114

DEVELOPMENT SERVICES DEPARTMENT
PERMIT & LICENSING DIVISION

DAYTONA METHADONE TREAT CENTE
1823 BUSINESS PARK BLVD
BUSINESS SERVICE
SUBSTANCE ABUSE CENTER
1MONL

| | |
|---|---|
| BT-34096 | BUSINESS TAX NO. |
| 34096 | ACCOUNT NO. |
| 09/30/1997 | VALID FROM |
| **09/30/2012** | VALID TO |
| 09/26/2011 | DATE PAID |
| $ 0.00 | AMOUNT PAID |

DAYTONA METHEDONE TREATMENT CT
DAYTONA METHADONE TREAT CENTE
1823 BUSINESS PARK BLVD
DAYTONA BEACH, FL 32114

DISPLAY AT PLACE OF BUSINESS FOR PUBLIC INSPECTION
**THE CITY DOES NOT CERTIFY OR IMPLY COMPETENCE OF BUSINESS**

**TAX RECEIPT**

9. Client Fee Schedule

## ACKNOWLEDGMENT OF FEE POLICY

Colonial Management Group, LP

Patient ID# _____

I _____;
(Patient Name)
understand that I am responsible for the payment of all fees under this program and do herby promise to pay for all such fees. If I am eligible for insurance I understand it is my responsibility to maintain my eligibility status. I further acknowledge that if my Insurance Carrier fails to pay / and or denies any services I am responsible for payment. If my account for any unpaid fees or other charges is referred for collection, I agree to pay any and all attorney's fees, collection fees and court costs related to the collection of my account. Pursuant to Federal Alcohol and Drug Confidentiality provisions, 42 C.F.R., Part 2, I authorize Colonial Management Group, LP to disclose my name and any of my records to any outside party and/or collection agency that may be needed or required to pursue collection of any delinquent monies I am responsible for and further authorize the outside party and/or collection agency to utilize those records, as they may require to collect any delinquent monies which I owe to Colonial Management Group, LP.

I acknowledge treatment fees have been explained to me. I also understand that these fees are subject to change or adjustment over time. The current fees are:

| | |
|---|---|
| Intake Fee: | $ 0.00 |
| Daily Methadone Fee | $ 14.00 |
| Monthly Fee | $ |
| Weekly Suboxone Fee | $ $175.00 |
| Monthly Fee | $ |
| Additional Urine Drug Screen Fee | $ 25.00 |
| Monthly Surcharge | $ |

By signing below I acknowledge and accept all terms and conditions related to the payment of the fees under my treatment.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

_____ _____
Staff Member Date

Form 7 (1-1-12)

# PATIENT ORIENTATION BOOKLET

Colonial Management Group, LP

Welcome to our treatment center. It is our pleasure to introduce our program to you. We have assembled a treatment program unlike many others, and we are pleased you have selected us to assist you in your recovery. You are not alone. We understand you and care about you. We believe our program truly offers an opportunity to break out of the addiction trap and to begin a new and satisfying life for you.

Along with an orientation session that you will receive soon, these few pages comprise our patient orientation to the program. Herein we describe our program and program philosophies intended to facilitate your recovery from narcotic addiction. **We expect you to faithfully attend all treatment activities, and we urge you to become fully involved in your own treatment and recovery.**

Please take the time to familiarize yourself with the contents of this orientation booklet and our program. Again, we are happy to meet you, and wish you a successful recovery and a productive life.

## MISSION

The mission of this treatment center, as part of Colonial Management Group, LP, is to be the premier provider of medication-assisted treatment in the United States. We believe in the disease concept of addictive illness and will treat our patients with dignity and respect in all phases of their treatment experience. Because of this belief we will focus our clinical practice in terms of disease management and strive always to improve the quality of the lives of the patients we serve. We will strive to institute current research findings in our delivery of services. We will also be a resource to the communities we serve by helping to educate the public on the disease of addiction and advocating at all times the value of treatment in improving the welfare of our communities. Our staff will at all times keep our mission statement as the guiding principle in their work.

## PROGRAM DESCRIPTION

Colonial Management Group, LP subscribes to the definition of opiate or opioid addiction as consistent with that of other addictive disorders: a pattern of pathological use marked by the physiological and psychological inability to abstain and impairment in social functioning, emotional and psychological health and stability, behavioral stability, interpersonal relationships and occupational functioning. Pathological use is often characterized by a myriad of problems or manifestations that include increased incidences of hospitalization, medical problems, arrests, increased involvement with the criminal justice system, loss of friends or negative changes in family and interpersonal relationships, inability to maintain employment, increased financial problems, acting out through anti-social behavior and at a more personal level, loss of self-esteem, self-confidence, and a decreased sense of personal responsibility. The Colonial Management Group, LP's opioid treatment program focuses exclusively on those patients with an addiction to opiates/opioids and attempts to help them achieve abstinence and experience recovery from opiate addiction.

## TREATMENT PHILOSOPHY

We believe that treatment services should be delivered in a way that respects the dignity and self-worth of every patient and are relevant to the diversity of our patient population. We believe that treatment and recovery are very personal experiences with distinct physical, mental, emotional and spiritual components that may differ significantly from patient to patient. We believe that each patient has a right to be fully and completely informed about the services we provide and our approach to treatment. Most importantly, we believe that each patient brings unique life experiences to the treatment environment and plays a vital role in treatment planning, service delivery and discharge/transition planning. Additionally, we are convinced that addiction is a family disease and is best treated within that context. Therefore, we encourage and support, through fully informed patient consent,

the involvement of family members and/or significant others in educational programs offered by the organization and, in actual counseling sessions and treatment activities. Finally, we recognize our moral and ethical responsibility to provide the highest quality treatment services that hold the greatest promise of successful outcomes for our patients.

| **HOURS OF OPERATION** | **Weekdays** | **Weekends** |
|---|---|---|
| Administration and counseling hours | _____ | _____ |
| Medication hours | _____ | _____ |

**Special hours for holidays will be posted in advance. You should always check the patient bulletin boards for special hours or events.**

Please take note that these hours are fixed and cannot be altered. **There are no provisions for calling in late or medicating after these hours. You will not receive medication after these hours.** Additionally, we ask that you arrive at the center at least 15 minutes before the end of medicating hours so that we are able to serve you as needed.

**TREATMENT FEES**

**You are expected to be responsible for your treatment fees. Fees are payable in cash, traveler's check, or money order. Personal checks will not be accepted.** Third-party payment may be arranged in some centers. Ask your counselor for details if you believe you are eligible for third-party payment.

Please understand, the center cannot accept payment from another patient or a family member for you without your written permission. To do so would constitute a violation of your right to confidentiality. Do not ask staff members to accept payment for you from another person.

**Non-payment of fees will result in initiation of involuntary medically supervised withdrawal and discharge.**

Our treatment fees include the following:

- The admission fee is: $_____.
- The daily methadone fee is: $_____.
- The weekly Suboxone fee is: $ 175.00 .
- The transfer fee is: $_____.
- Additional drug screen is $ 10.00 .

**PATIENT RIGHTS**

As a patient of this center, you have:

- The right to be fully informed about your course of clinical care and decisions that may affect your treatment;
- The right to revoke the consent for treatment at any time;
- The right to timely and accurate information to assist you in making sound decisions relative to your treatment;

- The right to be fully informed as an active participant in decisions pertaining to your treatment and to participate in all counseling/treatment modalities offered by the center;

- The right to have a primary Counselor designated in writing who will direct and coordinate your treatment;

- The right to request a change in your primary Counselor if you so desire;

- The right to receive services in an environment that is free of all forms of abuse, including, but not limited to, (a) fiduciary abuse, (b) physical abuse and punishment, (c) sexual abuse and exploitation, (d) psychological abuse including humiliation, threats and exploitation, and, (e) all forms of seclusion and restraint;

- The right to have information about your treatment and your confidentiality protected to the greatest extent allowed by federal and state confidentiality laws and regulations;

- The right to file a grievance or complaint about the services you receive without fear of retaliation or reprisal of any sort;

- The right to have family members, friends, or others involved in your treatment with your consent or approval;

- The right to receive services that comply with all laws, rules, and regulations regarding opioid agonist treatment;

- The right to file a grievance with the state licensing/regulatory authority or other state agency if you feel that the organization has not satisfactorily addressed any concerns you have or, does not adequately address any formal grievance you submit; and

- Upon acceptance by another opioid treatment program, the right to transfer if you notify your primary Counselor in advance of your desired transfer date so that the center staff can assist you in a smooth transfer to another program.

You may also have additional rights afforded to you based on the rules and regulations for methadone treatment in your state. Your primary Counselor or the Program Director can advise you of any additional rights you may have.

**PATIENT RESPONSIBILITIES**

- Refrain from all forms of physical violence or abuse toward other patients or staff members;

- Refrain from abusive language, disruptive behavior, or overt sexual conduct toward other patients or staff members;

- Not loiter outside the center;

- Not bring any weapon, gun, or other form of illegal contraband into the center;

- Not bring any illicit (illegal) drug or alcohol onto center property;

- Refrain from using illicit drugs or alcohol and recognize that any such use may, at the discretion of the staff, constitute grounds for therapeutic discharge from the program;

- Refrain from smoking inside the center;

- Provide a urine drug screen sample upon request of your Counselor, nurse, or other staff member, and do so with the understanding that (1) you may be observed by a staff member of the same gender while producing the sample and (2) that providing a "cold sample" or refusing to provide a sample upon request is paramount to providing a positive sample;

- Attend all group or individual counseling sessions as required by your Counselor or center rules. A consistent failure to attend will affect your progress in treatment and could adversely impact your continued retention in the program;

- Inform your Counselor or nurse of any prescription or over-the-counter medications you are currently taking;

- Behave in a civil, decent, and respectable manner and treat other patients and staff members in the same way.

- Dress appropriately and recognize that you will not receive services if you are not wearing shirt and shoes.

- Office telephones are not available for routine patient use. Center staff members cannot take personal messages for you. Please do not give our office telephone number as a place where you can be reached.

- Recognize and acknowledge that a violation of these patient responsibilities can result in involuntary discharge from the program and a discontinuation of all services.

## GENERAL MEDICATING INSTRUCTIONS

**Sign the Daily Medication Sign-in Sheet.**

- **It is your responsibility to check the accuracy of all transactions at the pharmacy window**
- **Check any medication provided to you to ensure the dose amount is correct**
- **Check to make sure that the correct number of take-home doses, if any, have been provided to you**
- **Check to ensure that the amount of money paid by you is correct**
- **Placing your initials on the Daily Medication Sign-In Sheet constitutes your agreement that all transactions are correct**

Please remember, once you initial the Daily Medication Sign-In Sheet, you are confirming that the transaction is correct.

**Actions at the Pharmacy Window.**
Please do not wear sunglasses at the pharmacy window. The nurse must be able to make eye contact prior to providing medication. Additionally, the nurse will expect you to speak to them at the window to make sure you have swallowed your medication.

**Dose Changes**

Dose changes must be requested through your counselor. The counselor will initiate the request which must receive approval from the nurses, the Program Director, and the Medical Director before going into effect.

**Resumption of Dosing Following Absences**

Patients absent for three or fewer days may resume medicating at up to 100% of their last dose. At patient request, the dose may be lowered by following the protocol for dose changes. Patients absent 4 to 7 days must be seen by the Medical Director before resumption of dosing can occur. Resumption doses will be determined by the Medical

Director using the Clinical Opiate Withdrawal Scale. Patients returning after being absent for more than 7 days will be discharged and treated as a new admission.

**Take-home Medication**

The following take-home criteria will be used to determine if patients have demonstrated responsibility in handling unsupervised medication. Additional criteria may be used based on state regulations and the individual issues presented by each patient requesting take-homes.

1. Absence of recent abuse of alcohol or other drugs
2. Consistency/regularity of clinic attendance
3. Absence of serious behavioral problems
4. Consistency/regularity in therapy activity attendance
5. Absence of illegal activities
6. Stability of home environment and social relationships
7. Length of time in current treatment episode
8. Do the benefits of take-home medication outweigh the risk of diversion?
9. Is the patient responsible in storing medication at home, and in a locked box?
10. Is the patient fully and totally compliant with all policies, rules, and regulations?
11. Has the patient provided a current phone number for call-backs?

**The security, custody, and control of any take-home medication that you receive is your responsibility.**

**Indications that you are not responsibly controlling take-home medication will result in loss of this privilege. To receive take-home medication, you must pay for your medication in advance and bring a lockable, childproof container to store that medication. Periodically, staff members will check your take-home container to ensure it is serviceable. Patients are not permitted to share take-home containers. Take-home medication should not be left in automobiles or other hot places. Labels must not be tampered with, and bottles returned with labels defaced, torn, or peeled off are considered an indication of a lack of responsibility in handling take-home medication. Consuming your take-home medications earlier than the date labeled on the bottles will be considered diversion and will result in the loss of your take-home privileges. All take-home bottles must be returned on your next medication visit. Failure to return take-home bottles may result in loss of take-home privileges. If you are receiving take-home medication, you may be contacted and asked to return all bottles not yet consumed, as part of the center's diversion control policy.** If you are contacted, you must return unused medication within 24 hours. Failure to do so will be considered an act of diversion and you will lose your take-home privileges.

**Other Medications**

**If you are taking other medication along with your methadone, you must notify the medical staff of the clinic immediately. You are required to notify any doctor or dentist of your status as a methadone patient prior to receiving treatment from them.**

**HEALTH AND SAFETY**

The center and all staff members are dedicated to maintaining a healthy and safe environment for you and your family members. We welcome you to voice your concerns about any health or safety issue. You may do so by contacting the Program Director or any staff member.

The center maintains Emergency Policies and Procedures identifying actions to be taken in cases of emergencies. Unscheduled tests of emergency plans and procedures will be conducted periodically, and you may be asked to

evacuate the building as part of that test or drill. Please follow the directions of staff members during any drill or emergency.

Adequate first aid and fire prevention equipment is located throughout the center. Emergency exits are clearly marked for safe egress in the event of a power failure. Staff members are trained to handle emergency situations and to help you during emergencies.

The center maintains ready access to information on all patients that would be needed in the case of emergency situations by medical personnel. While you are not required to provide emergency medical information, we encourage you to do so and to ensure that information is current.

Keep your methadone out of the reach of children. If you are permitted to receive take-home medication, you must bring a lockable, childproof container with you to store your medication. Your medication does not need to be refrigerated, but should be stored in a cool, dry location. Do not store your medication in your automobile.

Remember that methadone works for you because over time you have become accustomed or tolerant to it. Persons without your level of tolerance cannot safely take methadone. Do not attempt to share or give your take-home medication to another person.

**Symptoms of methadone overdose include:**

- Nausea and vomiting;
- Constricted (small, pin-pointed) pupils;
- Drowsiness;
- Cold, clammy, bluish skin;
- Reduced heart rate;
- Reduced body temperature; or
- Slow, irregular, noisy breathing (unusual snoring), or no breathing.

If you suspect that someone has overdosed on methadone immediately call 911.

You must inform the treatment staff if you are taking any prescription medications. You are also responsible for informing any physician or dentist who is treating you of your status as a methadone patient.

Methadone taken in accordance with your Medical Director's schedule is safe. However, taking other drugs with your methadone can create a life-threatening hazard. All medications being prescribed to you should be discussed with your personal physician and the clinic's Medical Director to ensure your safety. Also, certain drugs may cancel out the effects of methadone and will put you into immediate drug withdrawal.

One of the effects of methadone is the blocking of the effects of other opiates/opioids. It is important that you inform your doctor and your dentist of your status as a methadone patient to ensure that you are prescribed appropriate medication should you require surgery or a dental procedure.

## FACTS ABOUT METHADONE AND HOW WE USE IT

You are being given a medication called methadone to prevent you from suffering any withdrawal symptoms from opiates/opioids. Methadone will also eliminate craving for other opiates/opioids and establish a blockade effect against other opiates/opioids. We will keep you on a constant dosage, established by the Medical Director.

It is extremely important that you medicate daily to maximize the effects of the medication.

Methadone is an addictive drug and has all the cautions associated with other opiate drugs. Withdrawal symptoms can occur if you fail to dose regularly.

Initially, you may find that methadone may cause some minor side effects, such as dizziness, lightheadedness, sleepiness, or upset stomach. Most patients tolerate any initial discomfort well; the effects ordinarily are only temporary. The only common longer-term side effects are constipation and excessive perspiration. If these symptoms occur, inform the nurse, counselor or Medical Director. Dose adjustments can relieve these side effects. If constipation continues, talk with the nurse, counselor or Medical Director. You may experience some difficulty urinating or may retain fluid. You may experience a loss of interest in sex or have difficulty in becoming sexually aroused. If this occurs, discuss it with the Medical Director. Sometimes, dose adjustment may be helpful. If you experience a rash or skin irritation, discuss it with the nurse or Medical Director. Experience has shown these side effects to be short-lived and transitory.

**Myths about methadone**

Methadone gets into your bones...

Methadone does not "get into your bones" or in any other way cause harm to the skeletal system. Although some patients report having body aches, the discomfort is probably a mild withdrawal symptom which may be eased through dose adjustments.

Methadone damages your body...

Patients have been taking methadone for more than 30 years and there is no evidence that long-term use causes any physical damage whatsoever. Some patients do have side-effects such as constipation, increased sweating and dry mouth but these usually go away over time.

Methadone harms your liver...

The liver breaks down and processes methadone but methadone does not harm the liver. Patients with hepatitis or other liver diseases can take methadone safely.

It's harder to kick methadone than dope...

Stopping methadone use is different than other drugs. Some find it harder because the withdrawal lasts longer due to the half-life of methadone. Others say that although the withdrawal is longer, it is milder than other drug withdrawal.

Methadone causes people to use cocaine...

Methadone does not cause people to use cocaine or any other drug. Many people who use cocaine started taking it before they started treatment with methadone and many stop using cocaine while they are being treated with methadone.

## EMERGENCY SERVICES

The clinic uses a pager system to reach staff members to provide emergency services to you during periods in which the clinic is closed. A digital pager is carried by a designated staff member at all times, so that you have emergency access to a staff member 24 hours per day.

If you have any serious adverse reaction to methadone, or methadone overdose, go to the closest hospital emergency room immediately. Inform the emergency room staff that you are receiving methadone and in what dosage. You may provide the clinic emergency pager number to the emergency room staff so they may contact our staff for assistance in treating you.

## COMMUNICABLE DISEASES AND INFECTION CONTROL

The clinic staff is required to report communicable diseases including Tuberculosis (but excluding the HIV virus) to the public health authorities. Should your laboratory tests indicate that you have a communicable disease, we will notify you and the health department of the test results. Should you have a communicable disease, you will

have the option of seeking treatment from your private physician or through the local health department at your own expense. You will be expected to seek treatment for your disease as a condition of remaining in treatment with us, and you will be asked to provide verification of obtaining that treatment. Should you refuse to seek treatment for any communicable disease, you will be required to undergo a medically supervised withdrawal from methadone and be discharged from treatment. Your counselor/case manager will assist you if this situation does arise. Your agreement with these provisions is a specific condition of admission to our treatment program;

**INVOLUNTARY DISCHARGE**

Despite our hope that all our patients succeed in treatment with us, there are times when a patient must be involuntarily discharged from treatment. We reserve the right to discharge you for the following reasons:

- You become inappropriate for methadone treatment by maintaining an involvement with alcohol and other drugs
- You refuse to honor program treatment policies and procedures
- You sell, attempt to sell, or otherwise divert any of the methadone provided to you
- You become verbally or physically abusive to staff or other patients
- You fail to responsibly attend to treatment fee obligations
- You become or remain sufficiently disruptive to the program or other patients or interfere with program operations or the treatment of other patients

You will be notified of any decision to begin involuntary medically supervised withdrawal and discharge from the program. Upon notification of the center's intent to involuntarily discharge you, you have the right to:

- Discuss your discharge with the Program Director
- Request a transfer to another treatment program
- Negotiate the length of the medically supervised withdrawal period
- Register a complaint or grievance with the licensing authority in your state (State Methadone Authority)

**LEAVING TREATMENT**

Leaving treatment is not just a matter of stopping your daily methadone or ceasing center attendance. Because you will become dependent on your daily methadone, a slow and controlled (MSW) period is in your best health interests. Sudden or abrupt cessation of your daily methadone will cause a rapid return of drug hunger or craving and return of withdrawal symptoms. A slow withdrawal period, designed by the center's Medical Director in consultation with you and your counselor, is best for you.

You may decide at any time to undergo medically supervised withdrawal and leave methadone treatment, and we will never deny you that right. All you need to do is to inform your counselor. We will help you decide if you are ready for medically supervised withdrawal and advise you on what is best and/or recommended, but the ultimate decision is yours.

When you decide to leave treatment, your counselor will help you design a transition plan to ensure continuity of services. This plan will identify your needs for support systems and will include referral source information.

**CONCLUSION**

You will be given a tour of the center and may be assigned additional groups as part of your orientation. If you or your family members have any questions about the center, your treatment, or the contents of this orientation booklet, please feel free to contact your counselor or the Program Director.

Again, we welcome you to the center, and we look forward to assisting you throughout your recovery.

**PATIENT'S AFFIRMATION**

By my signature below, I affirm that I have received a copy of the Patient Orientation Booklet, which includes a description of services, applicable fees, program rules, patient rights and responsibilities, limits of confidentiality, information on infection control, and patient grievance procedures. I further acknowledge that I have had the contents of the Patient Orientation Booklet explained to me, and that I agree to:

- keep the booklet;
- read the booklet completely;
- abide by its contents;
- follow all medical guidance provided me during my treatment;
- meet with my counselor as scheduled; and
- attend all scheduled group activities.

_____

Patient Signature/Date

_____

Counselor Signature/Date

(Instructions to intake counselor: Issue booklet to patient during first day intake. Remove this page and file it in the intake section of the patient's record.)